State of Connecticut

GENERAL ASSEMBLY

PERMANENT COMMISSION ON THE STATUS OF WOMEN

18-20 TRINITY STREET
HARTFORD, CT 06106-1628
(860) 240-8300
FAX: (860) 240-8314
Email: pcsw@cga.ct.gov
www.cga.ct.gov/PCSW

Testimony of
Natasha M. Pierre, JD, MSW
Associate Legislative Analyst
Permanent Commission on the Status of Women
Before the
Appropriations Committee
Friday, February 17, 2006

H.B. 5007 An Act Making Adjustments to the Budget for the Biennium Ending June 30, 2007

Re: Appropriations for the Department of Social Services

Good evening Sen. Harp, Rep. Merrill and members of the Committee. My name is Natasha Pierre and I am the Associate Legislative Analyst for the Permanent Commission on the Status of Women. Thank you for this opportunity to testify regarding proposed appropriations for the Department of Social Services.

The PCSW and members of the Connecticut Women's Health Campaign have a lot to say about how the DSS budget would affect health care for women and girls in Connecticut. It all comes down to three main points which we ask you to take to strengthen our health care system make it more efficient:

- make it easier for families to enroll in *and stay on* HUSKY;
- fully fund SAGA medical assistance and restoring SAGA transportation services; and
- reinvest the $61 million lapse in state Medicaid dollars back into Medicaid and SAGA medical assistance.

Fully Fund SAGA Medical Assistance
The PCSW and CWHC support full funding for health care safety net programs, including funding to restore the SAGA (State Administered General Assistance) medical program.

SAGA provides health care for approximately 31,000 of Connecticut's poorest residents. Health care coverage through SAGA is critical to low-income women in Connecticut, as 40% of the recipients are women.[1] Access to medical services that are covered under this program are limited.

SAGA Medical income eligibility is extremely stringent. The income ranges from $5,714 to $6,898 *per year* and cash assets are limited to about $1,000. (Income and asset rules vary depending on the region of the state)

Non-emergency medical transportation which allows these individuals to get consistent health care is no longer provided, along with several other services. Many SAGA beneficiaries are disabled and do not have transportation. Some are waiting for a final SSDI/SSI and Medicaid eligibility determination, which would provide transportation. This process can take 8 months to two years to complete. Health care may be available, but not accessible. Requiring people to go to Federally-qualified health centers (FQHCs) often means people have to travel very long distances to see a doctor.

The restructured SAGA program which took effect on October 1, 2004[2] caps funding to the hospitals and the Federally Qualified Health Centers, which are statutorily designated to deliver medical care. Connecticut hospitals need $15 million a year and FQHCs need an additional $5 million a year to cover cost of providing services.

As Connecticut continues to under fund public health insurance programs, true costs for this care are shifted to the privately insured. We urge the Appropriations committee to:

- Remove language that caps funding
- Restore non-emergency medical transportation as a covered service

HUSKY/Medicaid
HUSKY and Medicaid are of great concern to the PCSW and the Connecticut Women's Health Campaign because the majority of the over 90,000 adults on HUSKY A are women and there are probably more than 100,000 girls in HUSKY A.

Keep children eligible for HUSKY for one year
Continuous eligibility allowed children to keep HUSKY for up to one year from enrollment or renewal regardless of small fluctuations in income and prevented them from being bounced off and on the program. At least 7,000 children lost HUSKY coverage when we eliminated continuous eligibility in 2003. While OPM originally estimated $8 million in savings, there are substantial administrative costs involved in re-

[1] DSS Data.
[2] Conn. Gen. Stat. Section 17b-257 as amended by Section 43 of P.A. 03-03 (June Sp. Sess.).

determining children and families for HUSKY eligibility. Due to this, we estimate the short term costs to be much lower, by at least $1 million.

These costs further reduce the costs of uncompensated care and ultimately, provider rates for the privately insured as well. In 2004, the Connecticut Hospital Association estimated that the loss of CE and self-declaration of income could cost member hospitals $2.8 million.

Continuous eligibility addressed the "churning" in HUSKY, as families cycle on and off the program with temporary changes in their income. Studies have found that such gaps are more common and are growing longer. A national study found that 40% of those who spent any time in Medicaid/SCHIP left and reenrolled in one of these programs.[3]

Keep working families on HUSKY for up to 24 months -- Restore transitional or extended medical assistance "TMA"

Transitional Medical Assistance (TMA) helps whole families keep HUSKY coverage in spite of fluctuations in income. Families whose income puts them over the HUSKY A income guidelines of 150% of FPL ($24,135 per year for a family of three), keep their HUSKY coverage. TMA used to provide up to 24 months of continued HUSKY A coverage. In 2005, TMA was reduced from two years to one year.

A small percentage of HUSKY A families (less than 20% according to last year's DSS enrollment files) are receiving cash assistance. Many more HUSKY A enrollees are in working families with incomes below the poverty level. Currently, about 46,000 individuals are enrolled in HUSKY A through TMA.

While the primary source of health insurance is through employers for most adults in Connecticut, low-income workers are much less likely to have employer-sponsored coverage. A recent study found that *only 8 percent of low income adults have the possibility of obtaining employer-sponsored insurance* (ESI).[4]

Those most deeply affected by the cut in TMA are low-income working women who do not have employer-sponsored coverage.

- Nationally, over 30% of working women who left cash assistance remained uninsured after working for the same employer for 2 years or more.[5]
- Over half of women who leave welfare report at least one health problem. 22% of women said they had a health condition that limits the type or amount of work they can do.[6]

---

[3]M. Birnbaum and D. Holahan, Renewing Coverage in NewYork's Child Health Plus B program: Retention Rates and Enrollee Experiences. New York: United Hospital Fund, 200; and K. Lipson et al, Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs, Pub. No. 656. New York: Commonwealth Fund, August 2003.

[4] S. K. Long and J. A. Graves, *What Happens When Public Coverage Is No Longer Available?* The Urban Institute for the Kaiser Commissionon Medicaid and the Uninsured. January 2006.

[5] B. Garrett and J. Hudman, "Women who left welfare: health care coverage, access and use of health services." Kaiser Commission on Medicaid and the Uninsured, June 2002.

[6] B. Garrett and J. Hudman, "Women who left welfare: health care coverage, access and use of health services." Kaiser Commission on Medicaid and the Uninsured, June 2002.

- Of the 20,965 families still receiving cash assistance all but 8,411 are exempt from work requirements because of conditions which make them unable to work.[7] The Department of Labor (DOL) identifies barriers faced by employment services clients as it works with TANF clients. 9% cited health conditions as barriers to employment.

Health coverage, especially through TMA is a vital work support for working families and a major boost to family economic security.

Restore electronic verification (self-declaration) of income in HUSKY

OFA originally estimated Connecticut would save $2 million by eliminating self-declaration of income. Once again, we see that the administrative hassles for DSS workers ultimately result in higher administrative costs as well as reduced enrollment. Since July, 2005, 10,000 people lost HUSKY. Any savings come from keeping eligible families off of HUSKY, increasing the numbers of uninsured families in Connecticut.
This affects every new family applying for HUSKY.

With electronic verification, the state checks applicant income. Families write down their income on an application and sign a statement swearing that the information is true under penalty of perjury. HUSKY program staff then verifies the family's income through the Department of Labor, Social Security, and other electronic records. These procedures worked well for four years until they were eliminated in July 2005. The state checks for fraud while reducing duplicative paperwork for families and workers. Even the federal government encourages states to increase efficiency and productivity by allowing families to self-declare their incomes.[8]

In Connecticut, one-third of medical assistance, including HUSKY applications, are overdue. Federal law requires states to complete the eligibility determination within 45 days. The Legislative Program Review and Investigations report cited this as a problem and we urge to address it by restoring self-declaration of income.

Eliminate premiums and co-pays on HUSKY A adults
The legislature has authorized the Department of Social Services to impose $25 monthly premiums per adult and co-pays on HUSKY A adults with incomes between 100 and 150% of poverty ($16,090 to $24,135 per year for a family of three).

Research, as well as Connecticut's recent experience with imposing higher cost sharing on HUSKY B children, demonstrates that such cost sharing will cause a drop in enrollment. Thus, most of the "savings" from imposing premiums and co-pays will come from keeping *eligible* working parents and caretaker relatives off of HUSKY. The legislature should repeal the premiums and co-pays and prevent the confusion and

[7] Legal Assistance Resource Center. *The Betrayal of Welfare for Working Families.* November 2005.
[8] T. Westmoreland, Director, Center for Medicaid and State Operations and M. Mangano, Acting Inspector General, Office of the Inspector General, Letter to State Medicaid Director, Health Care Financing Administration, January 19, 2001.

administrative hassles which have plagued HUSKY B two years in a row with cost sharing increases and repeals.[9] Healthy children need healthy parents.

Fund outreach to help families apply for and keep HUSKY
State and national experiences demonstrate that providing outreach at targeted locations, such as schools, community health centers, and other provider sites, increases enrollment. One-on-one outreach is key.

Outreach efforts must focus on *retention* as well as enrollment given the complexity of the program.

Premium assistance in HUSKY
Very few of the low-income working age adults who are currently covered by public programs would have any insurance options in the absence of public coverage. *Only 8 percent would have the possibility of obtaining employer-sponsored insurance* (ESI).[10]

Fewer and fewer employees are being offered ESI. One study finds that only about one-third of 2003 high school graduates will have access to employer-sponsored health insurance coverage.[11] The CT OHCA estimates that 39% of small Connecticut firms do not offer ESI.[12]

The Kaiser Commission on Medicaid found that in order to realize savings, enrollment must be "robust." Since Connecticut no longer funds any outreach efforts for HUSKY, and since families are not well-informed about the nature of HUSKY, their managed care plan and their benefits package, a premium assistance initiative is unlikely to see high enrollment numbers. There is no conclusive evidence that premium assistance saves money.

Joan Alker of the Georgetown University Health Policy Institute has found that oversight of the benefit packages in premium assistance involves significant resources.
Since DSS does not have the resources to oversee and determine applications for the HUSKY program now, we think it is not a good idea to add a third layer of administration to the program. It would be best to put resources elsewhere, e.g. into outreach, on-line applications, or into modernizing the Eligibility Management System.

Finally, we urge legislators to think about whether it makes sense to use public dollars to subsidize private coverage.

State Regulations Define Medical Necessity
"**Medical necessity** or medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an

---

[9] In November 2005, the legislature repealed the new and increased premiums on HUSKY B children due to the inability of many HUSKY B families to pay the higher costs.
[10] S. K. Long and J. A. Graves, *What Happens When Public Coverage Is No Longer Available?* The Urban Institute for the Kaiser Commissionon Medicaid and the Uninsured. January 2006.
[11] Hacker, J.S. *Ibid.*
[12] Connecticut Office of Health Care Access Small Employer Survey, 2004.

individual in *attaining or maintaining* an *optimal level of health*; to diagnose a condition; or prevent a medical condition from occurring. "

Redesigning this definition would limit health services by:

- **overruling treating providers' best judgments on appropriate treatment**
- **the proposed definition shifts the burden of proof to the** provider **to provide scientific studies supporting his/her proposed treatment**
- **creating larger problems with specialty care capacity in Medicaid.**

Restricting the definition of medical necessity would, in theory, be a way to reduce utilization of services, and therefore service dollars up front. However, these assumptions are problematic for a number of reasons. National data show that Medicaid patients don't over utilize health services. In fact, since capacity in the system is already limited by low reimbursement rates this change could have a chilling effect on specialty care in Medicaid…eliminating access to specialty care.

The changes would create a potential windfall for managed care organizations and not result in savings for the state. *Maintaining* a health condition is not a commercially used clinical standard, must show improvements within a specified limit/duration/scope of treatment. The commercial standard is to show improvement within a very limited course of treatment. Commercial standards are set by utilization management staff at MCOs who often do not have any personal clinical knowledge of the patient.

The proposed change undermines the goal of "assist[ing] an individual in attaining or maintaining an optimal level of health." "Attaining… an optimal level of health" goes beyond the lesser duty to "treat, rehabilitate or ameliorate a health problem or its effects". For example, a Medicaid managed care organization could decide that an adolescent girl with a chronic disability would have to show improvement with 12 visits of specialty care. If the teen did not show improvement at the end of the 12 authorized visits, they would not have to provide any more care even if it would improve her health.

These changes would be inappropriate for the clients currently served by the HUSKY/Medicaid program. Medicaid was designed to serve a lower-income population, to counter the long-term health effects of poverty. That is precisely why the definition of medical necessity includes the goals of maintaining a health condition and realizing optimal health.

Conclusions

A troubling common thread in two of the Governor's proposals is to use public dollars to increase private health care resources. PA would represent a cost-shift to the private market and MN changes would result in less care with increased MCO profits.

The restorations would make Connecticut's health care system more efficient by making it easier for families to enroll in and stay on HUSKY, and reduce the number of uninsured people seeking costly emergency department care.

HUSKY and SAGA Medical Are Not Just Budget Lines
They're LIFELINES.